Winlock Eye Care Clinic Confidential Medical History Date: _____

Full Name: _____ Date of Birth: __/__/___ SS: _____ Gender: M/F

Address: _____ City/State/Zip: _____

Cell Phone: _____ Work/Home Phone: _____ Email: _____

Name of Spouse/Parent (circle one): _____ Medical Doctor: _____

List any allergies to medicines: _____

List any medicines or medications you take with dosage/frequency (including birth control, aspirin, OTC, home remedies) _____

_____

List all major injuries, surgeries, and hospitalizations: _____

_____

Last physical exam: _____ Last eye exam: _____ Are you pregnant or nursing? Yes/No

Race:
□ White
□ Asian
□ Black/African American
□ American Indian/Alaska Native
□ Native Hawaiian/Other Islander
□ Prefer not to specify

Ethnicity:
□ Hispanic or Latino
□ Non Hispanic or Latino
□ Prefer not to specify

Communication Preference:
□ Telephone
□ Email
□ Mail

Whom may we thank for referring you to our office?
□ Insurance Company
□ Phone Book
□ Newspaper/Ad/Website
□ Doctor
□ Friend/Family Member: _____

Preferred Language:

□ English □ Spanish □ Other _____

Eyewear History: Do you wear glasses? YES NO

□ Distance ONLY glasses □ Reading ONLY glasses □ Bifocals/Trifocals □ No Line Bifocals (PALs)

Do you wear contact lenses? YES NO

□ Soft Contact Lenses □ Gas Permeable Contact Lenses (Rigid) □ Multifocal or Monovision

Have you had LASIK/Refractive Surgery (PRK/RK)? YES NO

Personal/Family History: Please answer the questions below regarding YOU or YOUR FAMILY (parents, grandparents, siblings, children) for the following:

	You		Family			Relationship (mother, brother, etc)
	Yes	**No**	**Yes**	**No**	**?**	
Crossed Eyes/Lazy Eye	□	□	□	□	□	_____
Glaucoma	□	□	□	□	□	_____
Macular Degeneration	□	□	□	□	□	_____
Retinal Detachment	□	□	□	□	□	_____
Cataracts	□	□	□	□	□	_____
Cancer	□	□	□	□	□	_____
Diabetes	□	□	□	□	□	_____
Heart Disease	□	□	□	□	□	_____
High Blood Pressure	□	□	□	□	□	_____
High Cholesterol	□	□	□	□	□	_____
Thyroid Disease	□	□	□	□	□	_____
Other_____	□	□	□	□	□	_____

Approximate Height:_____ Approximate Weight:_____

Social History: Please choose all that apply:

□ Student
□ Reading
□ Swimming
□ Sports
□ Golf
□ Fishing

Alcohol Use
□ None
□ less than 1/day
□ 1-2 drinks/day
□ 3+ drinks/day

Tobacco Use
□ Never Smoked
□ Former Smoker
□ Current daily smoker
□ Smokeless (chew/dip)
□ Vape

Occupation: _____

Employer: _____

Review of Systems: Do you currently have or have you ever had any problems in the following areas:

	YES	NO
Constitutional		
Fever/Weight changes	□	□
Integumentary (Skin)		
Rosacea	□	□
Skin Cancer	□	□
Neurological		
Headaches	□	□
Migraines	□	□
Seizures	□	□
Multiple Sclerosis	□	□
Parkinson's Disease	□	□
Eyes		
Blurred vision	□	□
Distorted vision/halos	□	□
Loss of side vision	□	□
Double vision	□	□
Dryness	□	□
Mucous discharge	□	□
Redness	□	□
Sandy or gritty feeling	□	□
Itching	□	□
Burning	□	□
Glare/Light sensitivity	□	□
Foreign body sensation	□	□
Eye injury/trauma	□	□
Floaters in vision	□	□
Flashes of light	□	□
Psychiatric		
Anxiety	□	□
Depression	□	□

	YES	NO
Ears/Nose, Mouth, Throat		
Seasonal Allergies	□	□
Dry throat, mouth	□	□
Respiratory		
Asthma	□	□
Emphysema/COPD	□	□
Vascular/Cardiovascular		
Heart/vascular disease	□	□
High blood pressure	□	□
High cholesterol	□	□
Stroke		
Endocrine		
Diabetes	□	□
Thyroid disease	□	□
Gastrointestinal		
Acid reflux	□	□
Genitourinary		
Kidney/bladder disorder	□	□
Bones/Joints/Muscles		
Rheumatoid arthritis	□	□
Lymphatic/Hematologic		
Anemia	□	□
Bleeding problems	□	□
HIV/AIDS	□	□

Other: _____

Lifestyle Questions: Do you…? (Please mark all that apply)

□ Plan to get new glasses today?
□ Spend time outdoors?
□ Tend to scratch your glasses easily?
□ Feel bothered by glare and reflections?
□ Wish you had thinner and lighter lenses?
□ Have more than 1 pair of current prescription glasses?
□ Prefer not to wear glasses at times?
□ Work on a computer?
□ Wear sunglasses when outside?
□ Have an interest in trying contact lenses?

Our office requires payment at the time of service for all professional services and materials not covered in full by your insurance. By signing this form, you are authorizing Winlock Eye Care Clinic to file your insurance claims for this and all subsequent visits. You are also acknowledging that you agree to Winlock Eye Care Clinic's Financial Policy Agreement. You are responsible for all fees that your insurance will not cover. Your information is protected by our privacy policy. Your signature here acknowledges that you have received a copy of Winlock Eye Care Clinic's Notice of Privacy Practices and consent to Winlock Eye Care Clinic's use and/or disclosure of your protected health information to carry out treatment, payment, and healthcare operations.

Patient Signature: _____ Date: _____